MEDICARE + CHOICE APPLICANT
PHYSICIAN INCENTIVE PLAN DISCLOSURE INSTRUCTIONS

General Instructions for Submission: Hard copy Physician Incentive Plan (PIP) Disclosure is required only for new applicants for Medicare+Choice Contracts, except for Private Fee For Service Plans or non-network Medicare Savings Account Plans. Organizations that already hold a Medicare contract with HCFA must disclose electronically. PIP guidance, an extensive **Qs & As**, and all forms are available at HCFA's web site:

www.hcfa.gov/medicare/physincp/pip-info.htm

A hard copy disclosure must be included in the completed application, as directed within the application form. The disclosure should represent physician incentive arrangements for providers within the Managed Care Organization's (MCO) network at the time the application is submitted. A Medicare PIP disclosure includes:

The disclosure **Cover Sheet** - This sheet should be the *first page of the PIP submission*.

PIP Disclosure Form - This form may be duplicated as necessary to capture all of the arrangements in effect amongst the applicant's provider contractors and subcontractors down to the level of physicians.

Using the HCFA PIP Provider Worksheet: The PIP Worksheet may be used as a guide in determining if there is substantial financial risk in any provider arrangement and to assist the MCO in entering data on the disclosure form. MCOs may modify the Worksheet for their internal use as long as the necessary information is captured that will document the data upon audit by regulators. Generally, a separate Worksheet should be used for each type of contractual relationship. Reproduce as many of these forms as needed. Do not submit the Worksheets, but retain them and any other supporting information for review by regulators.

The MCOs should analyze the data from different providers to determine whether information from the same type of contracting entity can be aggregated for disclosure to regulators.

MCOs need to determine if they have received all information from their contractors down to the level of physicians, even if the providers bear no risk or there is no substantial financial risk.

- An intermediate entity should report its direct contracts with physicians as well as arrangements with its physician groups and the physician groups' physicians. Even if there is no substantial financial risk in any contractual arrangement, the lower levels must be disclosed.
- A physician group should report arrangements with its physicians, even if there is no substantial financial risk between the MCO and the physician group.

Enter the information from the Worksheet on the appropriate lines on the Disclosure Form after indicating the specific contractual relationship being disclosed.

Using the PIP Disclosure Form for M+C Applicants: At the top of the Disclosure Form, *print the name* of the MCO, give the Medicare contract number, and the reporting year.

Nine contractual relationships are listed. Disclose one type of relationship on each Form you complete. Submit as many Forms as you need to represent all of the arrangements that serve the MCO's Medicare enrollees.

(1) _____ MCO to physician group
(2) _____ MCO to intermediate entity
(3) _____ MCO to individual physician
(4) _____ Intermediate entity to physician group
(5) _____ Intermediate entity to physician
(6) _____ Physician group to physician group
(7) _____ Physician group to physician
(8) _____ Physician to physician
(9) _____ Intermediate entity to intermediate entity

Each submission from an MCO must include contractual relationships (1), (2) or (3), but MCOs may have multiple arrangements and need all three. Then the MCO must disclose the subcontracting arrangements to the

level of the physician. All disclosures relating to one hierarchy of contracts should be stapled together. The hierarchies are:

Selection of: **(1) _____ MCO to physician group requires a disclosure of:**
(7) _____ Physician group to physician OR (6) _____ Physician group to physician group
If (6) is selected, you **must** have (7) to disclose incentives to physicians
There can be selection of: (8) _____ Physician to physician [this is not required]

Selection of: **(2) _____ MCO to intermediate entity requires disclosure of :**
(4) _____ Intermediate entity to physician group OR
(5) _____ Intermediate entity to physician OR
(9) _____ Intermediate entity to intermediate entity
The intermediate entity can have multiple contracting arrangements.

If (4) is selected, you **must** have (7) to disclose incentives to physicians
If (9) is selected, you **must** have (4) or (5) to disclose incentives to subcontractors
There can be selection of: (8) _____ Physician to physician [this is not required]

Selection of: **(3) _____ MCO to individual physician does not require any subcontract.**
There can be selection of: (8) _____ Physician to physician [this is not required]

Single or aggregate disclosure: The Disclosure Form may reflect a *single* incentive arrangement if that is a unique arrangement. However, MCOs should *aggregate* information on one Form for contractual arrangements that are substantially the same and the stop-loss requirements are the same.

> For example, if an MCO contracts with 100 physician groups under a very similar capitation payment that does not pass referral risk to the groups, the MCO should check category one on the Disclosure Form and disclose all 100 on one Form. If 55 physician groups do not pass risk to their doctors and these 55 groups have a total of 450 physicians under this no risk compensation, then the MCO should check category 7 on a new Disclosure Form and disclose all 450 on the Form. Similarly, the MCO should disclose the physician group-physician incentive arrangements for the other 45 groups, aggregating those physicians who are placed at substantially the same risk and who have the same stop loss requirements, if the risk exceeds the SFR cutoff. Staple together all the forms that relate to the 100 physician groups.

Entering the information: After checking the relationship you are disclosing, follow the directions below.

1. **On line 1.A**., give the name or identifier of a single provider (e.g., the intermediate entity, physician group, or individual physician) or the providers who are aggregated for the disclosure. The provider named or identified is the party who receives payment under the provider contract to which the Disclosure Form applies. The purpose here is to allow the user to be able to identify the provider(s) after entering the data.

   On line 1.B., give the number of aggregated providers whose arrangements are being disclosed. (See the discussion above.) Do not send lists of provider names. For example, if #1 is selected, then give the number of physician groups.

   Line 1.C. asks for disclosure of Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHCs). Please distinguish FQHC/RHCs by using a separate Disclosure Form to report each FQHC/RHC, however you may aggregate those with substantially the same incentive arrangements. If the MCO is owned or controlled by a consortium of FQHC/RHCs or has FQHC/RHCs in its network, be sure to indicate this on the cover sheet.

Line 1.D. applies only to physicians of physician groups (selection of #7 contracting type) and asks for a breakout of the number of physicians who are members of the group and those who independently contract with the group. Members are typically owners, partners, or employees of the physician group.

If either arrangement with providers that are intermediate entities (IE) is selected on the Disclosure Form (either #2 or #9), complete items 1.A - 1.C only since stop loss requirements do not apply to intermediate entities (IE). However, fully complete disclosures for IE's relationships with provider groups and their physicians (#4 and #7) and IE with individual physicians (#5) because stop loss requirements apply to these levels.

2. **Question 2** identifies whether the incentive arrangement transfers any risk. A capitation payment is considered a transfer of risk for this question, even if the capitation is for services provided only by the contracting physician or physician group. [This information is found in the Worksheet.]

   Check "yes"or "no" as applicable. If "no" is checked, then this disclosure is complete. If "yes" is checked, identify the type of risk transfer; then go to Question 3.

   Risk transfer choices are: "capitation, bonus, withhold, percent of premium or other." *Check the appropriate choice* or choices; more than one choice should be checked if the arrangement has features of each type of risk-sharing.

   A choice of "Other" is provided if a combination of the four types of risk arrangement does not define the arrangement. For the purpose of this Disclosure Form, the obligation for the provider to fund deficits is considered as a "withhold." A bonus for low utilization of referral services is considered to be risk transference.

3. **Question 3** identifies whether risk is transferred for referrals. [This information is in the Worksheet.] *Check "yes"or "no"* as applicable. A bonus for low utilization of hospital, specialist or other services is considered to be a risk for referral services. If "no" is checked, then this disclosure is complete. If "yes" is checked, go to Question 4 to identify the type of risk transfer.

4. **Question 4** identifies the type of risk-sharing arrangement. [This information is found in the Worksheet.] See #2 above for instructions on identifying risk arrangements.

   The risk-sharing arrangement may be described briefly on the Disclosure Form, particularly if 'other' is selected. [This information should be available in the Worksheet from the contractors.]

5. The percentage of risk ***attributable to referrals only*** should be stated in **Question 5**. This percentage corresponds to the "% Of Total Compensation At Risk For Referrals" from the Worksheet. If the percentage is equal to or below 25 %, the arrangement is not considered to be at substantial financial risk and this disclosure is complete. Percent of premium is treated as capitation for this calculation. If above 25 percent, proceed to Question 6.

6. Information for **Question 6**, about the number of patients, is found in the Worksheet. Specific criteria must be met before pooling is allowed, as stated in regulations. Any entity that meets all five criteria (below) required for the pooling of risk will be allowed to pool that risk in order to determine the amount of stop-loss required by the regulation. If the number of patients is 25,000 or fewer, then go to Question 7. If greater than 25,000, the disclosure is complete.

   (1) Pooling of patients is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or group (i.e., no contracts can require risk be segmented by MCO or patient category);

(2) The physician or group is at risk for referral services with respect to each of the categories of patients being pooled;
(3) The terms of the compensation arrangements permit the physician or group to spread the risk across the categories of patients being pooled (i.e., payments must be held in a common risk pool);
(4) The distribution of payments to physicians from the risk pool is not calculated separately by patient category (either by MCO or by Medicaid, Medicare, or commercial); and
(5) The terms of the risk borne by the physician or group are comparable for all categories of patients being pooled.

Note that pooling and stop-loss requirements applicable to a group cannot be extended to a subcontracting level. For example:

- A physician group has greater than 25,000 patients that meet pooling criteria.
- This group contracts with another physician group, which has 25,000 or fewer patients and bears risk for referrals above 25%.

The first group is exempt from stop-loss requirements; the second group must comply with stop-loss requirements and the MCO must comply with survey requirements.

7. For **Question 7**, note the type and the levels or thresholds of the stop-loss insurance if stop-loss coverage for the physician group or physician is required.

Check the type of stop-loss, aggregate, individual per patient, or other coverage.[*] If individual, give the threshold (deductible) as a *dollar amount*. If *aggregate* or *other* briefly describe the stop-loss coverage. If there are arrangements that merit explanation, describe the coverage (if needed, attach a sheet for additional space).

A description should include whether the coverage is:
(1) Combined (professional and institutional);
(2) Broken down into institutional, professional and other components;
(3) The deductible, co-insurance percentage, maximum liability/pay-out by the policy;
(4) Whether the stop-loss coverage applies to all costs or only the cost of referral services; and
(5) Any other key features of the coverage.
This information is found in the Worksheet.

If providers can be aggregated because of the similarity of risk arrangements, the MCO should sort the providers by stop loss requirements and then use a separate Disclosure Form for each requirement. For example: 100 groups exceed the 25% risk threshold; 50 have a patient pool exceeding 25,000 (under a very similar risk arrangement); 25 have a patient pool of between 1,001 and 5,000 (under a very similar risk arrangement); and another 25 of these groups have a patient pool of between 8,001 and 10,000. The MCO should use three Disclosure Forms to represent the groups that aggregate into three stop loss requirements.

[*] Aggregate insurance is excess loss coverage that accumulates based on total costs of the entire population for which they are at risk and which provides reimbursement after the expected total cost exceeds a pre-determined level.
Individual insurance is where a specific provider excess loss accumulates based on per member per year claims.